

PRÉCIS OF ISSUES PERTAINING TO THE DEATH OF JULIEKA DHU

Compiled by
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PART I – CIRCUMSTANCES SURROUNDING THE DEATH

- (1) On the 2nd of August 2014 the Deceased, Julieka Dhu, aged 22, a person of Indigenous Australian ethnicity, was arrested by the Western Australia Police Force (WA Police Force) and held at the South Hedland Police Station lockup, for outstanding fines in the sum of approximately one thousand dollars (\$1000.00), in accordance with Western Australian State Government Policy of holding persons in custody to serve time in gaol in lieu of payment of outstanding fines.
- (2) The boyfriend of the Deceased, Dion Ruffin, was arrested on the 2nd of August 2014 in company with the Deceased for a breach of a Restraining Order pertaining to a female person other than the Deceased.
- (3) The Deceased was held in isolation in a police cell.
- (4) Ruffin shared a cell with one Malcolm Dick Wilson, a person unrelated to and unknown theretofore to the Deceased, Ruffin, and their respective families.
- (5) Soon after incarceration the Deceased became gravely ill and beseeched Police for medical assistance.
- (6) According to witnesses Ruffin and Wilson, Police largely ignored the Deceased's cries of pain and requests for medical assistance.
- (7) The Deceased died on the 4th of August 2014.
- (8) During the period of her incarceration the Deceased was taken by Police in a police motor vehicle on two occasions to the Hedland Health Campus for assessment, allegedly by Police certified there by medical personnel on both occasions as fit for holding in the Police cell. The Deceased was returned to the police station by Police in a police motor vehicle and returned to her isolated cell on both occasions without receiving any medical treatment.
- (9) On the 4th of August 2014 the Deceased became very distressed, according to witnesses Ruffin and Wilson, pleading for her life and for urgent medical assistance. A Police Officer or several Police Officers entered her cell. According to witnesses, the Deceased was literally dragged from the cell and conveyed, not by ambulance, but

by Police in a police motor vehicle, for a third and final time, to the Hedland Health Campus, where she was pronounced dead.

(10) During the time in which the Deceased was in custody her grandmother, Carol Roe, telephoned the South Hedland Police Station inquiring as to the Deceased's condition but was not told by Police that the Deceased was ill.

PART II – ACTIONS SUBSEQUENT TO THE DEATH

- (1) A post-mortem examination of the Deceased was carried out by Forensic Pathologist Dr. Jodi White. Preliminary forensic report noted that the Deceased 'may' have had a fractured rib at the site or near the site of two previously fractured but healed ribs, that the Deceased had bleeding into a least one of her lungs, that the deceased had a head wound, that the Deceased had dried vomit in her mouth and over her body. It has been reported by another unnamed medical practitioner that the Deceased may have died from septicaemia. The cause of death has not been made clear.
- (2) The post-mortem examination was carried out in the presence of six (6) Western Australia police officers, but in the absence of any representative of the Deceased's family and in the absence of a medical practitioner for the Deceased's family, despite the Deceased's family's legal rights to such representation.
- (3) There was a Coronial Inquiry, expedited at the request of the Premier of Western Australia, Colin Barnett, owing to public outcry. The Coronial Inquiry has not fully answered questions concerning the death of the Deceased and remains inadequate.
- (4) The Internal Affairs Branch of the WA Police Force carried out an investigation. Its findings have not been made public.

PART III – OCCUPATIONAL HEALTH AND SAFETY ISSUES SUBJECT TO INVESTIGATION

- (1) The Occupational Safety and Health Act (1984) [OS&H Act] of the State of Western Australia binds the Crown.
- (2) Police officers are deemed by the OS&H Act to be employed by the Commissioner of Police (who is not a State Minister), and hence the Crown.
- (3) The Attorney General of Western Australia, Michael Mischin, a Government Minister, is on record, stating publicly that the Western Australia Government does indeed have a Policy of holding persons in custody in lieu of payment of outstanding fines, and that he supports this Policy.
- (4) The Minister for Police, Liza Mary Harvey, is responsible for the Western Australia Police Force and its Police Commissioner, Lawrence Panaia, who

directs and executes the aforementioned Government Policy under the Office of the Minister for Police.

- (5) The Premier of Western Australia, Colin Barnett, is party to the said Government Policy of incarceration in lieu of payment of outstanding fines.
- (6) The South Hedland Police Station is a place of work for police officers of the State of Western Australia.
- (7) The police officers on duty during the time of the Deceased's custody at the South Hedland Police Station and lockup have a statutory Occupational Safety & Health Duty of Care for all persons at their workplace, including detainees.
- (8) The Police failed to monitor or adequately monitor the Deceased whilst in Police custody.
- (9) An OS&H Policy must be in written form and posted in such a place that all WA Police Force employees have easy access to it and be adequately trained and informed as to this OS&H Policy. There is no evidence that such a Policy was in place and made known to police officers at the South Hedland Police Station during the time of the Deceased's detention. There is no evidence that the police officers at the South Hedland Police Station during the time of the Deceased's detention were trained or instructed or adequately trained or instructed in OS&H Policy and related appropriate standards to fulfil such a 'Policy'. There is no evidence of an OS&H Committee for the South Hedland Police Station. There is no evidence of an appropriate System of Work or an adequate System of Work at the South Hedlands Police Station, meeting the requirements of OS&H statutory obligations. There is no evidence of an OS&H Management System pertaining to the South Hedlands Police Station and its employees. There is no evidence of suitable Safe Work Method Statements being in place relating to the appropriate care of prisoners in WA Police Force detention and control, particularly for those who report illness or exhibit symptoms of illness. There is no evidence that the WA Police Force and its Policy makers have fulfilled their 'due diligence' obligations as required under the OS&H Regulations (Reg. 1.12), being a guideline set by the NHOSC, as well as a general principle of OS&H application across Australia when conducting their work activities.
- (10) OS&H Duty of Care cannot by law be delegated to subordinates, associates or contractors engaged in an undertaking at a workplace. Those in charge of undertakings at a workplace are just as responsible as those who carry out subordinate tasks at that workplace. Those in charge of a place of work and employees at that place of work can be held personally responsible at law for their acts and/or omissions that occasion injury or death to any person at their workplace owing to negligence or gross negligence at their workplace. Government Ministers evade such personal responsibility owing to specific Legislation excepting them, but this is not the case for Officers of the said Ministers and not for the Commissioner of Police himself.

- (11) The Office of the Premier, the Office of the Minister for Police, the Office of the Attorney General, and the Commissioner for Police are statutorily obliged to consult one another as to OS&H Policy and produce written evidentiary OS&H Policy and all must satisfy the additional statutory requirement of setting up between themselves an Occupational Health & Safety Management System at least to Australian Standard 4801 and construct written instruments for this System. Failure to do so is an offence under the OS&H Act, and is subject to substantial fines.
- (12) It is mandatory at OS&H law that a death at a workplace be immediately reported to the Commissioner (i.e. WorkSafe Western Australia Commissioner). Prima facie evidence suggests that the Deceased died whilst in the custody of Police, either at the cell in which she was held or in the police motor vehicle when she was transported to the Hedland Health Campus by WA Police Officers. Should OS&H investigation prove this to be true, then the Offices of the Premier, Minister for Police, and the Attorney General, and also the Commissioner for Police, have all committed an offence by failing to report a death at the workplace they control and/or direct, and in accordance with Government Policy of gaol in lieu of payment of fines, and this offence is subject to substantial fines being applied to them all.
- (13) There is no evidence that any responsible person for the Office of the Premier, the Office of the Minister for Police, the Office of the Attorney General, or the Office of the Commissioner for Police, holds any or any adequate qualifications in OS&H in order to discharge statutory obligations pertaining to OS&H. Failure to train or adequately train personnel to a level to enable them to discharge OS&H statutory obligations for the organisation undertaking the workplace activities is an offence, subject to substantial fines for all offenders.
- (14) The Charter of WorkSafe Western Australia explicitly states that if the Police are involved in the investigation of a workplace incident, WorkSafe will conduct a parallel and independent investigation into that incident. In the case of the Deceased the situation is very different, because although the Police Internal Affairs Branch has conducted an investigation into her death, it is the Police Force itself which is the subject of investigation. The Police Force thereby has a conflict of interest in this particular matter, not just on account of Police investigating Police, but also due to the fact that the WA Police Force is an executive arm of Government, by which the Office of the Premier, the Office of the Minister for Police, and the Office of the Attorney General are all implicated.
- (15) Police have alleged that two medical certificates, one on each of two separate occasions, were issued by medical staff at the Hedlands Health Campus, attesting that the Deceased was fit to be held in a police cell. The identities of those issuing the certificates have not been disclosed by Police or by the Regional Director of Hedland Health, Ron Wynn, or by the Coroner. The alleged medical certificates have not been produced in evidence. There is no evidence that the Deceased was examined by any qualified medical practitioner. It is curious that if she was in actual fact examined by a qualified

medical practitioner that the Deceased was not then recognized by that qualified medical practitioner as suffering from a serious illness requiring urgent medical attention. There is no evidence of any medical intervention whatsoever. The identities of those issuing the alleged medical certificates should be ascertained and those persons interviewed, along with any other persons who attended upon the Deceased at the Hedland Health Campus. The Regional Director of Hedland Health, Ron Wynn, should also be interviewed.

- (16) The identities of all police officers at the South Hedland Police Station at the time of the Deceased's detention should be identified, in particular those who put hands on the Deceased and those, if not the very same officers, who were involved in her detention, and all those persons interviewed.
- (17) The responsible officers for the Premier, the Attorney General, the Minister for Police, and the Commissioner for Police should be identified and interviewed as to the existence of an Occupational Health and Safety Management System (OHSMS) to AS 4801* compliance, and the existence of an OS&H Policy. The Commissioner for Police should also be interviewed since, by virtue of his position, he knew or ought to have known his statutory obligations at OS&H. Similarly, the responsible officers for the aforementioned Ministers knew or ought to have known their statutory obligations at OS&H. If upon OS&H investigation an AS 4801 OHSMS between all parties is discovered, then it should be examined to ascertain actual compliance by all parties to it, and the management standards of it examined for compliance, to ensure the AS4801 OHSMS is an active document with appropriate and inherent internal and external auditing being conducted and the identity of and qualifications of the auditors established and assessed.
- (18) There is no evidence that OS&H audits of the WA Police Force and in particular the South Hedland Police Station have been carried out by a qualified person from or for the Office of the Commissioner for Police, the Office of the Premier, the Office of the Minister for Police, or the Office of the Attorney General, and in particular in relation to Government Policy of incarceration of persons in lieu of outstanding fines.
- (19) Dion Ruffin, Malcolm Dick Wilson, Carol Roe, Shaun Harris (the Deceased's uncle), and the forensic pathologist Jodi White should all be interviewed. Wilson is currently serving a one year sentence for driving offences and is currently held at the Roebourne Regional Prison's work camp.
- (20) Should OS&H investigations uncover suppression of, destruction of, or tampering with evidence, or perjury, the person or persons involved should be referred to oversight authorities for criminal investigation, perverting the course of justice.

* AS = 'Australian Standard' as defined in the Occupational Safety and Health Act 1984, Western Australia, **Part I, Section 3** (1).

PART IV - SECTIONS OF THE OCCUPATIONAL SAFETY AND HEALTH ACT 1984 APPLICABLE TO THIS MATTER, WITHOUT EXCLUSION OF OTHER SECTIONS THEREOF

PART I, Section 3 (1),

Commissioner of Police means the person holding the office of Commissioner of Police under the Police Act 1892;

WA Police means the Police Force of Western Australia provided for by the Police Act 1892;

“workplace means a place, whether or not in an aircraft, ship, vehicle, building, or other structure, where employees or self-employed persons work or are likely to be in the course of their work.”

PART I, Section 3 (4),

For the purposes of this Act, a police officer is to be treated as an employee of the Crown and the Crown is to be treated as the employer of a police officer.

PART I, Section 3 (5),

Without limiting any other provision of this Act, a police officer is at work during any period of time when the officer is performing a function of a police officer, whether or not the officer is rostered on duty and, in relation to a police officer, the expressions “work” and “at work” are to be construed accordingly.

PART I, Section 4 (1),

This Act binds the Crown in right of the State and also, so far as the legislative power of the State extends, in all its other capacities.

PART I, Section 4 (1a),

The functions that the Crown has under this Act because a police officer is to be treated as an employee of the Crown are, so far as they concern a police officer, to be performed by the Commissioner of Police.

PART I, Section 5,

Objects

The objects of this Act are —

- (a) to promote and secure the safety and health of persons at work;*
- (b) to protect persons at work against hazards;*
- (c) to assist in securing safe and hygienic work environments;*
- (d) to reduce, eliminate and control the hazards to which persons are exposed at work;*
- (e) to foster cooperation and consultation between and to provide for the participation of employers and employees and associations representing employers and employees in the formulation and implementation of safety and*

- health standards to current levels of technical knowledge and development;*
- (f) *to provide for formulation of policies and for the coordination of the administration of laws relating to occupational safety and health;*
- (g) *to promote education and community awareness on matters relating to occupational safety and health.*

PART III, Section 20 (1),

An employee shall take reasonable care —

- (a) *to ensure his or her own safety and health at work; and*
- (b) *to avoid adversely affecting the safety or health of any other person through any act or omission at work.*

PART III, Section 20 (2),

Without limiting the generality of subsection (1), an employee contravenes that subsection if the employee —

- (a) *fails to comply, so far as the employee is reasonably able, with instructions given by the employee's employer for the safety or health of the employee or for the safety or health of other persons;*

PART III, Section 20 (3),

An employee shall cooperate with the employee's employer in the carrying out by the employer of the obligations imposed on the employer under this Act.

PART III, Section 20A,

(1) If an employee contravenes section 20(1) or (3) in circumstances of gross negligence, the employee commits an offence and is liable —

- (a) *for a first offence, to a fine of \$25 000; and*
- (b) *for a subsequent offence, to a fine of \$31 250.*

(2) If —

- (a) *an employee —*
- (i) *contravenes section 20(1) or (3); and*
- (ii) *by the contravention causes the death of, or*

serious harm to, a person; and

- (b) *subsection (1) does not apply, the employee commits an offence and is liable —*
- (c) *for a first offence, to a fine of \$20 000; and*
- (d) *for a subsequent offence, to a fine of \$25 000.*

(3) If —

- (a) *an employee contravenes section 20(1) or (3); and*
- (b) *neither subsection (1) nor subsection (2) applies,*

the employee commits an offence and is liable —

- (c) for a first offence, to a fine of \$10 000; and*
- (d) for a subsequent offence, to a fine of \$12 500.*

(4) An employee charged with an offence under —

(a) subsection (1) may, instead of being convicted of that offence, be convicted of an offence under subsection (2) or (3); or

(b) subsection (2) may, instead of being convicted of that offence, be convicted of an offence under subsection (3).

PART III, Section 21,

(2) An employer or self-employed person shall, so far as is practicable, ensure that the safety or health of a person, not being (in the case of an employer) an employee of the employer, is not adversely affected wholly or in part as a result of —

- (a) work that has been or is being undertaken by —*
 - (i) the employer or any employee of the employer;*
 - or*
 - (ii) the self-employed person;*

or

- (b) any hazard that arises from or is increased by —*
 - (i) the work referred to in paragraph (a); or*
 - (ii) the system of work that has been or is being operated by the employer or the self-employed person.*

PART III, Section 21A,

(1) If an employer or a self-employed person contravenes section 21(1) or (2) in circumstances of gross negligence, the employer or a self-employed person commits an offence and is liable to a level 4 penalty.

(2) If —

- (a) an employer or self-employed person —*
 - (i) contravenes section 21(1) or (2); and*
 - (ii) by the contravention causes the death of, or serious harm to, a person;*

and

- (b) subsection (1) does not apply, the employer or self-employed person commits an offence and is liable to a level 3 penalty.*

(3) If —

- (a) an employer or self-employed person contravenes section 21(1) or (2); and*
- (b) neither subsection (1) nor subsection (2) applies, the employer or self-employed person commits an offence and is liable to a level 2 penalty.*

(4) An employer or self-employed person charged with an offence under —

- (a) subsection (1) may, instead of being convicted of that offence, be convicted of an offence under subsection (2) or (3); or*
- (b) subsection (2) may, instead of being convicted of that offence, be convicted of an offence under subsection (3).*

PART III, Section 23A,

- (1) A person shall not —*
 - (a) engage in any activity, other than a prescribed activity;*
 - or*
 - (b) engage in a prescribed activity, other than in a prescribed manner, at a workplace in an area of the State prescribed for the purposes of this section.*

PART III, Section 23B,

(1) If a person contravenes section 23A in circumstances of gross negligence, the person commits an offence and is liable to a level 4 penalty.

- (2) If —*
 - (a) a person —*
 - (i) contravenes section 23A; and*
 - (ii) by the contravention causes the death of, or serious harm to, a person; and*
 - (b) subsection (1) does not apply, the person commits an offence and is liable to a level 3 penalty.*

- (3) If —*
 - (a) a person contravenes section 23A; and*
 - (b) neither subsection (1) nor subsection (2) applies, the person commits an offence and is liable to a level 2 penalty.*

- (4) A person charged with an offence under —*
 - (a) subsection (1) may, instead of being convicted of that offence, be convicted of an offence under subsection (2) or (3); or*
 - (b) subsection (2) may, instead of being convicted of that offence, be convicted of an offence under subsection (3).*

PART III, DIVISION 5, Section 23I, Notification of deaths, injuries and diseases,

- (1) In this section —*

business of an employer means —

 - (a) the conduct of the undertaking or operations of an employer; and*
 - (b) work undertaken by an employer or any employee of an employer;*

- (2) This section applies where —*
 - (b) at a workplace, a person who is not an employee incurs an injury in prescribed circumstances that —*
 - (i) results in the death of the person; or*

- (ii) is of a kind that is prescribed, in connection with —*
- (iii) the business of an employer; or*
- (iv) the business of a self-employed person.*

(3) The relevant person must —

- (a) forthwith; or*
- (b) as otherwise provided by the regulations, notify the Commissioner in the prescribed form of the injury or disease giving such particulars as may be prescribed.*

(4) The relevant person is the employer concerned where —

- (a) subsection (2)(a) applies; or*
- (b) the person incurs the injury in connection with the business of an employer.*

PART III, DIVISION 5, Section 23J,

(1) If an employer or self-employed person contravenes section 23I(3), the employer or self-employed person commits an offence.

(2) In proceedings for an offence under subsection (1) against a person who is taken by section 23D(2) to be an employer it is a defence if the person proves that subsection (4) applies.

(3) In proceedings against a person for an offence under subsection (1) that relates to an injury mentioned in section 23I(2)(b) it is a defence if the person proves that subsection (4) applies.

(4) This subsection applies if the person did not know, and could not reasonably be expected to have known, of the injury or disease concerned.

PART VII, DIVISION 2, Section 55B, Crown may be prosecuted,

The Crown in any capacity may, in accordance with this Division, be prosecuted for an offence against this Act.

PART VII, DIVISION 2, Section 55D,

(1) Where —

- (a) the act or omission constituting the offence is alleged against an agency or department that is an agent of the Crown (the responsible agency); and*
- (b) section 55C does not apply, the prosecution proceedings are to be taken against the Crown.*

(2) For the purposes of subsection (1) the WA Police is to be treated as an agency of the Crown.

(3) Proceedings referred to in subsection (1) may be brought against the Crown under the title “State of Western Australia”.

PART VII, DIVISION 2, Section 55E, Provisions applicable to responsible agency,

(1) In this section —

chief executive means the person who is for the time being responsible for the day to day administration of a responsible agency; prosecution proceedings means proceedings referred to in section 55D(1).

(2) For the purposes of prosecution proceedings —

(a) the responsible agency —

(i) is to be specified in the charge for the offence;

and

(ii) is entitled to act for the Crown in the proceedings; and

(iii) subject to any rules of court, has the procedural rights and

obligations of the Crown as the defendant in the proceedings;

and

(b) the complainant may during the proceedings, with the leave of the court, substitute another responsible agency for the agency in the proceedings.

PART V – AUSTRALIAN INSTITUTE OF PRIVATE DETECTIVES

The Executive Committee of the Australian Institute of Private Detectives (AIPD) has been advised of the notification of WorkSafe Western Australia of the death of Julieka Dhu and has been apprised of the facts concerning her case by means of this document, for purposes of monitoring and justice. The AIPD currently has submissions before State and Federal Governments, including the Federal Attorney General, concerning matters of competence, compliance, training, Occupational Health and Safety, and law, in relation to investigations conducted by both private and public agencies, and matters associated therewith, throughout the States and Territories of Australia.

Media reports clearly indicate that deaths in police custody is a National concern, not just a Western Australia issue relating to apparent OS&H negligence, and it is particularly disturbing that a high number of deaths in custody continues, some ten years after a Royal Commission into the issue. Media recently reported that some 320 or more deaths in police custody have occurred since the Royal Commission, averaging therefore at least 32 deaths across Australia each year. It is also a matter of great interest to know how many of those deaths were investigated by the relevant WorkCover Authorities and what recommendations, if any, were subsequently made to their respective Ministers, bearing in mind that the police are statutorily bound to report such deaths to their respective WorkCover Authorities, at pain of prosecution for failing to comply. There have been similar reported cases in the media over the past few years relating to the same problems in State prisons. People are dying in circumstances that are of great concern.

Since the Case of Julieka Dhu is a matter of considerable Public Interest, it is not only vital that a truly independent and transparent investigation be conducted by WorkSafe Western Australia, but that such investigation be conducted at the standard stipulated by all relevant State and Federal laws (i.e. by a qualified investigator meeting the

AQF standards, gazetted Federal Government Investigation Standards (AGIS), and Commonwealth Fraud Control Guidelines (CFCG,) to which State Authorities are bound under the certified education agreements between the States and the Commonwealth in order to meet the PSP04 Public Service training qualifications required under all State and Federal Occupational Health and Safety statutes, and in compliance with the investigation industry National Code of Practice (CoP) (see http://www.aipd.com.au/pdf/COP_Adopted220908.pdf) which WorkCover Western Australia openly supported, I understand, in 2004/2005 when the National CoP was first formulated). Furthermore, subject to the findings of WorkSafe WA investigation into the death of Julieka Dhu, stringent recommendations should be conveyed to the Western Australia Government in order to prevent such serious incidents at workplaces, to facilitate timely investigation of such matters by WorkSafe WA, and to imbue general Public confidence that OS&H laws will be upheld without fear or favour. In this regard I cite WorkSafe Western Australia's statutory function and responsibilities as specified in the **Occupational Safety and Health Act 1984 – Section 14.**

WorkSafe Western Australia

OCCUPATIONAL SAFETY AND HEALTH ACT 1984 - SECT 14

14. Functions of Commission

- (1) The functions of the Commission are —
 - (a) to inquire into and report to the Minister upon any matters referred to it by the Minister; and
 - (b) to make recommendations to the Minister with respect to —
 - (i) this Act; and
 - (ii) any law or provision of a law, relating to occupational safety and health that is administered by the Minister and any law or provision of a law relating to occupational safety and health that is prescribed for the purposes of this paragraph; and
 - (iii) subsidiary legislation, guidelines and codes of practice proposed to be made under or for the purposes of any prescribed law;

and

 - (c) to examine, review and make recommendations to the Minister in relation to existing and proposed registration or licensing schemes relating to occupational safety and health; and
 - (d) to provide advice to and cooperate with Government departments, public authorities, trade unions, employer organisations and other interested persons in relation to occupational safety and health; and

- (e) to formulate or recommend standards, specifications or other forms of guidance for the purpose of assisting employers, self employed persons and employees to maintain appropriate standards of occupational safety and health; and
 - (f) to promote education and training in occupational safety and health as widely as possible; and
 - (g) in cooperation with educational authorities or bodies to devise and approve courses in relation to occupational safety and health; and
 - (h) having regard to the criteria laid down by the National Occupational Health and Safety Commission, to advise persons on training in occupational safety and health and to formulate and accredit training courses in occupational safety and health; and
 - (i) **to recommend to the Minister the establishment of public inquiries into any matter relating to occupational safety and health; and**
 - (j) to collect, publish and disseminate information on occupational safety and health; and
 - (k) to formulate reporting procedures and monitoring arrangements for identification of workplace hazards, and incidents in which injury or death is likely to occur in an occupational situation; and
 - (l) to commission and sponsor research into occupational safety and health.
- (2) The Commission may issue for public review and comment any regulations, codes of practice or guidelines with respect to which it proposes under subsection (1)(b) to make any recommendations to the Minister.
- (3) The Commission shall ensure, as far as is practicable, that any information it provides is in such language and form as are appropriate for the persons to whom the information is directed.
- (4) The Minister shall within 60 days after receiving from the Commission a recommendation under subsection (1) make reply in writing to the Commission in relation to that recommendation.

[Section 14 amended by No. 43 of 1987 s. 11; No. 30 of 1995 s. 47.]

SUPPLEMENT – SEQUENCE OF REPORT EVENTS

(Added to this document on the 25th of November 2014)

(1) On the 24th of October 2014 I, Stephen J. Crothers, sent an email to WorkSafe WA notifying it of the death of Julieka Dhu at a workplace controlled by the Western Australia Police Force. Here is my email:

From: Stephen Crothers

Sent: Friday, 24 October 2014 2:00 AM

To: Corp Info Requests - WS

Subject: NOTIFICATION OF DEATH AT A WORKPLACE

WorkSafe Western Australia,

NOTIFICATION OF DEATH AT A WORKPLACE

Miss Julieka Dhu died on 4 August 2014 whilst in Police custody in Western Australia because Police failed to exercise their Occupational Health and Safety Duty of Care at a Police workplace. Police failed to provide Miss Dhu with urgent medical attention and failed to monitor her whilst in their custody. She consequently died, aged 22, as a result of Police gross negligence.

I request a WorkSafe investigation into this death.

The Executive Committee of the Australian Institute of Private Detectives has been copied this email.

Stephen J. Crothers
(Private Detective, retired)
Queensland

(2) On the 24th of October 2014 WorkSafe WA replied to my email and assigned a notification reference number.

(3) On the 6th November 2014 a WorkSafe WA Inspector emailed me requesting telephone contact for discussion of the case.

(4) On Monday the 10th of November 2014 I was telephoned by an Inspector of WorkSafe WA. We discussed the case.

(5) On the 11th of November 2014 I sent to WorkSafe WA by email my Précis of this case. Here is my email (the identity of the WorkSafe Inspector I have suppressed due to confidentiality of investigations).

XXXXXX,
Inspector, Services,

WorkSafe | Department of Commerce
WA

Dear XXXXXX,

Pursuant to our telephone conversation yesterday (Monday, 10 November 2014) concerning the death of Julieka Dhu at a workplace, I have prepared a summary of the salient facts and matters of investigation, which is attached for your information.

As I said during our conversation, I am available for further discussion.

Yours faithfully,
Stephen J. Crothers
(Private Detective, retired)

(6) On the 13th of November 2014 a WorkSafe WA Inspector emailed me asking if I had any additional information to provide, including any statements or other documents.

(7) On the 13th of November 2014 I replied to the email noted in (6) above. Here is my email (the identity of the WorkSafe WA Inspector I have suppressed due to confidentiality of investigations).

Dear XXXXXX,

I have not conducted an investigation into this case. Consequently I have not interviewed any witnesses and so I have no statements, or other documents. That is the point; these are matters to investigate. Also, as I remark in my Brief, documents have not been adduced by Police to substantiate their allegations. For instance, where are the alleged medical certificates? Where are the OH&S documents? Do they even exist? They are all subject to investigation. Where is the Death Certificate? Who pronounced Julieka Dhu dead? Where is the post-mortem report? Police have alleged she died at hospital. That allegation must be investigated. Prima facie evidence suggests that she died whilst in police custody. Where did she take her last breath? She was pronounced dead at hospital. The person who pronounced her dead must be identified and interviewed. And even if OS&H investigation subsequently established that the Deceased actually died at hospital that does not exonerate anybody. After all, the Deceased's rib, lung, and head injuries, and her vomiting, did not occur at the hospital, she did not actually receive any medical treatment, it appears that she was not even examined by a qualified medical practitioner (since a medical practitioner would surely have recognised that the Deceased was gravely ill), and she was not monitored or adequately monitored whilst in police custody. The cause of death has not even been established, allegedly. That too is dubious. Did the post-mortem reveal any DNA evidence that suggests assault upon the Deceased, including sexual assault? All these issues must be fully investigated in the OS&H independent inquiry.

It is highly unusual that 6 police officers should attend a post-mortem. In fact, I have never heard of this before. That 6 police officers apparently attended rings an alarm bell, especially since there was no medical representative for the Deceased's family in attendance. All 6 police officers at the post-mortem need to be identified and

interviewed. The person who instructed those Officers to attend the post-mortem should also be identified and interviewed. What other forensic personnel were present other than Jodi White who conducted the post-mortem? It is possible but unlikely that White acted alone. Any other person at the post-mortem must be identified and interviewed. There is serious concern in my view that evidence in this case is being deliberately compromised. Such evidence is directly associated with OS&H because this death is the result of a workplace incident or series of incidents or a continuous transpiration of circumstances. This case also has serious potential for criminal charges.

I know what I would do if I was conducting this investigation. I wish I was conducting this investigation. I plan to follow this case to its conclusion. If I can be of any assistance to WorkSafe WA during the OS&H investigation I will gladly assist. There is provision in the OS&H Act 1984 for an Inspector to be accompanied by an appointed Assistant, the latter being empowered to conduct inquiries in accordance with their expertise relevant to the case. I am willing to fill such a role, without fee for service.

Yours faithfully,
Stephen J. Crothers
(Private Detective, retired)

(8) On the 14th of November 2014 I received an email from a WorkSafe WA Inspector advising me that WorkSafe WA had commenced an investigation into this case under Occupational Safety and Health legislation.
